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PUBLIC HEALTH REPORTS

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THE PUBLIC HEALTH SERVICE IN TIME OF WAR.

EXECUTIVE ORDER MAKING THE UNITED STATES PUBLIC HEALTH SERVICE A PART OF THE MILITARY FORCES OF THE UNITED STATES.

Under the authority of the act of Congress approved July 1, 1902, and subject to the limitations therein expressed, it is ordered that hereafter in times of threatened or actual war the Public Health Service shall constitute a part of the military forces of the United States, and in times of threatened or actual war the Secretary of the Treasury may, upon request of the Secretary of War or the Secretary of the Navy, detail officers or employees of said service for duty either with the Army or the Navy. All the stations of the Public Health Service are hereby made available for the reception of sick and wounded officers and men, or for such other purposes as shall promote the public interest in connection with military operations.

[Signed] WOODROW WILSON.

THE WHITE HOUSE, *3 April, 1917.*

STANDARD MORBIDITY TABLES.

THEIR SIGNIFICANCE TO PUBLIC HEALTH ADMINISTRATION.

The purpose of a health department is to maintain the population, in so far as possible, in a condition of physical well-being or, what amounts to the same thing, to prevent the occurrence of disease.

Either to maintain the health of the population or to prevent the further occurrence or spread of disease, it is necessary that the places in which cases of disease are occurring and the conditions under which they occur be known and investigated. Not only must the places and conditions where disease is occurring be known, but the times of the year when disease is most prevalent and the sex and age, as well as the occupations, of those most frequently attacked must be known. In localities having satisfactory registration of deaths health officers have in the past been in the habit of studying these things as regards cases of disease which happen to terminate fatally. There has usually been no similar study of the far more numerous cases which terminate in recovery. Study has been limited to the fatal cases because there were usually available what were believed to be fairly dependable data regarding the deaths, while similar data regarding the nonfatal cases were supposed to be, and usually were, less complete.

For the purposes of the health department the study of fatal cases only has always been recognized to be at best a half-way measure. The health officer and the epidemiologist have studied mortality because of whatever value it possessed as an index of the prevalence of morbidity. While the life insurance company is naturally interested in the frequency of death, the health officer and the sickness insurance company are interested in the frequency of disease. Disease is represented by the cases and is as prevalent as the cases, and nothing short of a study of all cases will ever be satisfactory to the epidemiologist, nor will anything less than a study of all the known cases give to the health department the information it should have in order to attain a reasonable efficiency.

At the present time many municipalities and a number of States are getting reports of a considerable proportion of their cases of certain diseases. The time has come, therefore, when the health departments of these municipalities and States may begin to study intelligently and carefully the actual prevalence and distribution of these diseases in their respective territories.

While realizing that the mortality data represented only the relatively small proportion of cases which by chance were fatal, these data have in the past been carefully analyzed to get all the possible information they would yield of the prevalence of disease. They have been studied by sex distribution, by age distribution, by geographic distribution, by chronological distribution, and by occupational distribution. Wherever reasonably complete data of cases are available, an intelligent health department will study at least as carefully and as minutely the distribution of disease as shown by the occurrence of cases. In fact, the cases would warrant a more extensive study by the health department, for the cases represent the thing being studied and are not merely an index of the prevalence of the thing. Statistically the detailed analysis of cases as a study of disease prevalence and distribution rests upon a much sounder basis than the study of deaths by causes.

The action taken by the recent conference of State and Territorial health authorities with the Public Health Service in adopting minimum standard morbidity tables for publication in annual reports of State and Territorial authorities is of special moment. The standard adopted calls for the publication of data showing the distribution of cases of the notifiable diseases (1) chronologically by months, (2) by sex, (3) by 5-year age groups up to 25 years, and by 10-year age groups after 25 years, (4) by termination (recovery or death), and (5) geographically by counties and municipalities. Undoubtedly municipal health departments will also adopt these as minimum data to be given in their annual tabulations and publications.

The cumulative information which will be made available by the adoption of these tables and the publication of the specified data in annual reports will be of the greatest value to health administration. How great the value will be can hardly be appreciated at the present time.

TYPHOID FEVER.

RECORDED PREVALENCE BY STATES, 1916.

The following table shows the recorded prevalence of typhoid fever in the several States during the calendar year 1916. The records for the States of Kansas, Maryland, Massachusetts, Minnesota, Mississippi, Montana, New Jersey, New York, and Washington, and the District of Columbia appear to be relatively complete. In these States there were between 7 and 10 cases reported for each death registered. In Maryland there were 10 cases reported for each death. This is the highest ratio of any of the States. The next highest ratio is that of Massachusetts, with an average of more than 9 cases reported for each death.

Typhoid Fever Reported During the Calendar Year 1916.

State.	Cases reported.	Deaths registered.	Indicated case rate per 1,000 inhabitants.	Indicated death rate per 1,000 inhabitants.	Indicated fatality rate per 100 cases.	Estimated population July 1, 1916.
Alabama	3,591	694	1.540	0.298	19.33	2,332,608
Arizona	51		.200			255,544
California	1,205	209	.410	.071	17.34	2,938,654
Colorado	542		.563			962,060
Connecticut	538	93	.432	.075	17.29	1,244,479
District of Columbia	308	46	.846	.126	12.50	363,980
Hawaii	212	44	.983	.204	20.75	215,741
Indiana	3,296	600	1.170	.213	18.20	2,816,817
Iowa		155		.070		2,220,321
Kansas	2,104	263	1.150	.144	12.50	1,829,545
Kentucky		695		.292		2,379,639
Louisiana	1,413	347	.772	.190	24.56	1,829,130
Maine	426		.551			772,489
Maryland	2,668	267	1.958	.196	10.01	1,362,807
Massachusetts	1,515	161	.407	.043	10.63	3,719,156
Michigan	2,225	405	.728	.133	18.20	3,054,854
Minnesota	916	127	.402	.056	13.86	2,279,603
Mississippi	6,035	668	3.092	.342	11.07	1,951,674
Montana	407	47	.886	.102	11.55	459,494
New Jersey	1,390	194	.472	.066	13.96	2,948,017
New York	4,417	593	.430	.058	13.43	10,273,375
Ohio	4,273		.830			5,150,356
Oregon	210	52	.251	.062	24.76	835,471
Pennsylvania	8,697		1.021			8,522,017
Rhode Island	170	37	.277	.060	21.77	614,315
South Carolina		475		.292		1,625,475
Texas		523		.118		4,429,566
Vermont	165	24	.454	.066	14.55	363,699
Virginia		546		.249		2,192,019
Washington	615	78	.401	.051	12.68	1,534,221
West Virginia	1,469		1.060			1,386,038
Wisconsin	999	173	.400	.069	17.32	2,500,350
Wyoming		20		.111		179,559